SUBMISSION TO ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

SUBMITTED BY

[redacted]

ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Submission

Submitted by [redacted] 20 June 2019

Introduction:
This submission relates specifically to my son [redacted] who died on 23 April 2014 from self-immolation.

The details of the deterioration in [redacted] mental health are outlined in a document I prepared in 2016 titled 'The Death of [redacted]s: Looking for Answers', which is attached to this submission. The document was also provided to the Royal Commission in to Victoria's Mental Health System at a community consultation in Sunshine on 7 April 2019.

This submission will refer to my 2016 document as well as reference to a submission I made to the Victorian Coroner in which I was challenging the Coroner's 'Finding into Death Without Inquest' which concluded that an inquest was not necessary. I submitted a Request for an Inquest on 26 April 2019 into [redacted] death on the basis of a number of matters that I considered were serious deficiencies in the mental health system. I repeat my concerns in this submission.

In making this submission I am unsure of the information that may be subject to any privacy or confidential requirements concerning the identification of individual mental health practitioners, or the Coroner's Court material. I seek the assistance of the Royal Commission in redacting any material that may be subject to privacy or other confidential requirements.

Having set out my specific concerns as they relate to the circumstances concerning [redacted] I then address the various questions that the Royal Commission has requested be addressed in any submission.

Summary:
In summary, my submission is that [redacted] mental health was in decline for a number of years leading to a situation in which he was identified as a risk to himself and others. There is no doubt that he was a complex individual who was capable of erratic and unpredictable behaviour. He professed to be able to regenerate himself from fire and was incapable of looking after himself in relation to any but the basic human needs. He certainly was not capable of dealing with accommodation, financial matters, personal hygiene or diet. Yet for all of these deficiencies and an assessment that he was a risk in July 2013, he was released into the community and as a consequence, he self-immolated in April 2014.

I believe the evidence that I have set out in my 2016 document indicates that there were significant deficiencies in the processes and decision making that eventually resulted in [redacted] death.

Discussion:
Let me provide some extracts from the document I prepared in 2016 which I believe shows unambiguously that there was sufficient evidence to show that [redacted] was a risk to himself and the community and he should never have been released into the community.

Refer to the document 'The Death of [redacted]s: Looking for Answers' (pp. 14/15)

> *The following extracts are taken from material prepared by Dr. [redacted] Consultant Psychiatrist, Victorian Institute of Forensic Mental Health to Professor Warwick Brewer, North West Mental Health, dated 9/7/2013.*
>
> ...
>
> *On the basis of the above risk factors, [redacted] would be in a group of persons with a moderate to high risk of violence towards others. A likely scenario would be violence in response to psychotic symptoms or towards individuals who frustrate his wishes...* (p.15)

I comment at page 16 as follows:

> *Although Dr. [redacted] states that she considers a 'diagnosis of schizophrenia the most likely', she goes on to state that his behaviour 'may be the result of a head injury with executive dysfunction, although his previous head injury would not seem to be of sufficient severity to cause this'*
>
> *Different clinicians seem to refer to [redacted]ead injury' as a potential source for his erratic behaviour yet dismiss it on the basis that it was of insufficient severity to be the cause.*
>
> *I repeat the comments of Dr. [redacted] above who stated that: 'the exact nature and significance of the head injury on the development of his psychiatric illness remains unclear ...'*

I have referred to the two extracts above to make two obvious points:

1. There was sufficient evidence to indicate that [redacted] was a moderate to high risk of violence to others;

2. The nature of [redacted] 'illness' was ambiguous with the head injury creating some uncertainty as to its effect.

The document goes on to state that:

> *In July 2013, Dr. [redacted] Director Clinical Quality & Safety and Chief Psychiatrist, Department of Health sent an email to Dr. [redacted] which included the following comments:*
>
> *I have read the report provided by Dr. [redacted] ... and the report of Dr. [redacted]. I believe both reports are carefully considered by the authors and provide sound advice; it is most unlikely that I would make any suggestions which are in disagreement with the recommendations provided in the reports. Specifically, it is most unlikely that I would support the discharge of the patient from [redacted] given his risk profile and presence of on-going psychotic symptoms"* (My emphasis) (p.17)

Notwithstanding these comments concerning [redacted] s risk and the uncertainty as to the origins of his illness [redacted] Program Manager, [redacted] wrote to Dr. [redacted], Consultant Psychiatrist at [redacted] on 25 September 2013 in the following terms:

> *As I discussed with you ... after an extensive clinical review, including second opinion consultation ... have made the decision to discharge [redacted] from [redacted]*
>
> *The treating team has been able to establish that [redacted] psychosis is largely the result of his illicit drug use and that depot medication, paliperidone, is adequate treatment except when [redacted] escalates his drug use, particularly amphetamines.*
>
> *[redacted] has spent long periods of AWOL in the community over the past 11 months and each time returned to AMHRU with no or minimal change in his mental state. He also finds accommodation, manages his finances and looks after himself adequately during these times without running into serious trouble with the Police.(p.17)*

How the treating team arrived at the conclusion that [redacted] could find accommodation, manage his finances and look after himself is beyond comprehension. [redacted] was incapable of the most basic human needs including feeding himself and personal hygiene.

I refer you to p.17 of my 2016 document and the following comments from Dr. [redacted]:

> *There were no significant issues during AWOL, including no issues with police and he was able to live out of [redacted] successfully, finding his own accommodation, food and even work. During his approved and unapproved leaves from [redacted] Mr. [redacted] was able to take care of himself and his mental state remained stable, with little evidence of psychosis ...*

These comments bear little relationship to reality. [redacted] could not deal with the basics of life and the suggestion that he was in anyway a competent functioning individual is simply contrary to the reality of those of us who dealt with [redacted]

Consideration of the report provided by [redacted]l, Victorian Case Management Services Pty Ltd at pp.18/19 provide an insight into the daily life of [redacted] prior to his death. Note in particular:

> *22/11/2013:*
> *... [redacted] presented as quite delusional and paranoid as he was talking about other people's blood running through his veins and that people were watching him.*
>
> *4/2/2014:*
> *The writer received a call from [redacted] in the afternoon (approx. 5:30pm) stating that [redacted] had been kicked out of [redacted] Tourist Park and he has nowhere to stay.*
>
> *7/2/2014:*
> *The writer received a phone call from the [redacted] manager at approximately 9am stating that [redacted] has to leave due to his behaviour.*

[redacted] was a time-bomb waiting to go off. He had made it clear to anyone who would listen that he could withstand fire and could regenerate.

It is interesting to note the following comments from Dr. [redacted] to [redacted] on 18 September 2013 concerning [redacted] (p.17 2016 Document):

> *As discussed, in the context where we do not have access to a more secure but less restrictive environment (such as [redacted] or a medium secure unit), I agree that there is little benefit to Mr. [redacted] continuing admission to [redacted] ...*

This comment by Dr. [redacted] appears to be acknowledging that:

(a) There are no facilities which are appropriate for individuals with complex needs such as [redacted] and

(b) Given the lack of those facilities, there was no other option than to release [redacted] into the community.

If my understanding of Dr. [redacted] comments is correct surely it is time to acknowledge these serious deficiencies in our system. If I am correct in my assessment of Dr. [redacted] comments, [redacted] was literally discarded because there were no specific facilities available for him.

I have set out what happened to [redacted] and his mental state in the period between being 'evicted' by [redacted] and his death in my 2016 document. It was a time of intense 'madness' with J[redacted] being incredibly delusional and paranoid.

I believe that the evidence I have set out provides very clear evidence that there were significant deficiencies in the processes and decision making that eventually resulted in the death of [redacted]

I note at this point that following an investigation of the death of [redacted] the Coroner determined that an inquest was not required. I have challenged that finding and have submitted a case for an inquest to be held.

My request for an inquest incorporated the matters set out above from my 2016 document and included the following comments:

> *How was it possible that in July 2013 it was recommended that because of his risk factor and the complexity of his illness that he would not be released, yet in September 2013 it was decided he would be released on the specious grounds that he could 'look after himself'?*
>
> *There is ample evidence that [redacted] was in a very agitated state and exhibited paranoia and delusional behaviour after leaving [redacted] yet there was apparently no capacity within the system to affectively monitor or assess his mental health. He had effectively been abandoned. The circumstances surrounding [redacted] 's death indicate that there are many unanswered questions concerning the mental health system and the way it deals with complex individuals.*
>
> *The system we have appears to be unable or unwilling to deal with complex and difficult cases. Why is that? Did the clinicians simply run out of patience with [redacted] 's aberrant behaviour and discard him? Why did [redacted] die an excruciating death in the context of very clear clinical assessments that he was a risk to himself and others?*
>
> *Why was he discarded to fend for himself? Was it because we don't have the expertise to cope, or perhaps we don't have the physical resources? What policy options exist to deal with complex individuals? Are those individuals simply left to the vagaries of competing and unco-ordinated clinical assessments?*
>
> *The policy (if that is what it is called) that at-risk individuals can be 'released' into the community is fraught with problems. The decision to allow [redacted] into the community knowing his behaviour and the risk associated with that behaviour was to condemn him to the inevitable outcome that occurred. This aspect of [redacted] 's death cries out for a detailed examination – it is for that reason that I am seeking a Coronial Inquest.*

There is an additional matter that arose from the Coroner's investigation and initial findings that I believe should be raised in the context of the Royal Commission and that relates to what the Coroner referred to as 'case conferencing'.

The Coroner addressed the value of case conferences which could include the client, their family, and members of each agency where there are multiple agencies involved. This would appear to be a valuable proposal, however, from my perspective, in relation to any recommendation that a complex patient be released into the community, I propose that a case conference be compulsory and that it would include the client, their family, the relevant mental health practitioners involved in the patient's care and all relevant case notes relating to the client's treatment. Had that been the case with [redacted] it may have been possible to ensure that he was not released into the community, with the consequences that followed.

Quite apart from 'case conferencing' there are a number of important questions that arise from [redacted] s experiences with the mental health system:

1. To what extent is the current mental health system able to deal with complex and seriously at-risk individuals?

2. Does the mental health system have the expertise to deal with complex and seriously at-risk individuals?

3. Does the mental health system have facilities which are specific to the needs of complex and seriously at-risk individuals?

4. To what extent is there a need to better integrate the various clinicians' assessments and reports concerning complex and at-risk individuals?

5. To what extent is the mental health system capable of adequately assessing and monitoring complex and at-risk individuals who are released into the community?

I don't pretend to have the answers to all of these questions, however, from my perspective of a mother who watched the slow, painful decline of my son over a period of ten years or so as he worked his way through the mental health system, it is my belief that the short answer to each of the questions I have posed is the mental health system is beset by many failings. I have identified some key issues above which relate particularly to the way in which complex and difficult patients like [redacted] are treated. I would like to add the following comments, although I also address some of them in my responses to the questions posed by the Royal Commission.

As a complex and difficult patient [redacted] could sometimes be defiant and obstinate. I have observed both nurses and security deal with him aggressively and sometimes brutally. I do not deny that [redacted] could be difficult but surely there are other options than brute strength and threatening behaviour from nurses and security staff.

I was often concerned that the manner and attitude of nursing staff to patients left a great deal to be desired. I hasten to add that there were staff who seemed prepared to try and understand and communicate with patients, however, they were few and far between and it was my view that whatever training both nursing and security staff had they were poorly equipped to work effectively in a mental health facility.

There were occasions when I was visiting [redacted] that I observed patients who appeared to be collectively 'out of it'. I could only assume they had been medicated to the point at which they were no longer making demands on staff. Certainly, when I was in a mental health facility as a patient, I can recall the same thing occurring. If this is a widespread practice it surely must be addressed. The patients vary in their distress and need to be treated with care and understanding, they should not be drugged out of their minds. This practice may be a product of low staffing levels, or other reasons: whatever the reason it needs to be addressed and the practice stopped.

I refer to my experience as a mental health patient because it arose from the demands of attempting to deal with [redacted]'s mental health as it spiralled out of control. I, like many mothers I am sure, attempted to assist my child who was in a state that made no sense. How could this be? What was happening to my son, who was prior to being hit by a motor bike a relatively normal adolescent? I felt guilt, I thought I could support my son with love and affection, and I tried to deal with what was a constant state of distress and madness that enveloped my son. I can say now in retrospect that I was out of my depth and slowly drowned in a mess of confusion, hurt, anger, frustration and disappointment. I had literally nowhere to go for support, and when things became really difficult with [redacted] absconding from his facility, which he did often, I was caught between the Police who didn't want to know about a mental health patient who had 'gone missing' – contact the facility they would say – and when I contacted the facility they would say contact the Police. In the meantime, [redacted] would arrive at my home in a troubled and often paranoid state claiming that the voices in his head were causing him terrible distress. As a result of this never-ending cycle I got to the stage where I decided that I could no longer cope, and I attempted suicide. It was at that point that I was placed in a mental health facility to enable to me take stock of my life and build the strength to try and support [redacted] again. It took a terrible toll on my life and my marriage, and to this day I do not believe that I have been able to fully resolve everything that occurred during what was a ten year period of a living hell as I tried to deal with my son's distress and a mental health system that seemed to have little interest in my own distress.

There must be ways that individuals like myself can obtain support and assistance. My experience is that as the primary carer for [redacted] my capacity and ability to deal with what was a world I had never known and one that I didn't understand, was not a matter that the mental health system was interested in. This is a strange approach because it is clear that individuals like myself can and should play a large part in the treatment and care of patients like [redacted] but if we are bewildered, confused, worn out and likely to be unstable because of the stress and anxiety that we are under, that support will not be available.

Royal Commission Questions:
I now turn to addressing the questions posed by the Royal Commission. There are some questions I do not believe I am qualified to comment on and consequently I have removed those questions from this submission.

Question 4:
What makes it hard to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

This question is very broad and there are a number of comments I would like to make:

(a) Prior to my son becoming mentally unstable my understanding of mental health and mental health facilities was that these terms referred to people who suffered from some unknown problems and they acted strangely in public. In fact, my only experience of mental health issues was the occasional odd person that I saw who demonstrated peculiar behaviour in public. Although I have suffered from depression for some years, I did not understand or acknowledge that I might have had mental health issues. My point is that to be suddenly thrown headlong into the reality of mental health issues with all of the complexities that [redacted] demonstrated, including the uncertainty as to who to see and where to go, resulted in serious confusion, uncertainty and anxiety. When I did make contact with the 'mental health system' I was then confronted with very different language, treatments, numerous doctors and nurses and facilities. Then, on top of that came the Police when [redacted] was in a state of serious paranoia. On one occasion there were about twelve police at my house dressed in armour with growling police dogs.

What is needed is a central agency of some sort that provides an initial point of reference for people like me who can talk to someone and get advice and guidance about where to go and who to see. The agency could also assist in clarifying some of the strange and incomprehensible language used by doctors and nurses: to assist in better understanding what is happening to our loved ones. It could also assist in dealing with the Police, who seem to be a constant presence in the mental health system.

(b) I have referred above to the lack of interaction between the Police and mental health facilities. When your loved one is vulnerable and obviously in a state of confusion and apparently 'lost', it is understandable that you will be beside yourself with anxiety. To then be tossed between the Police and the mental health facility creates an intolerable burden. The relationship needs to be clarified and the respective individuals need to be responsive to both the 'patient' and the family who are in a state of anxiety and stress concerning their missing loved one.

(c) [redacted] had his finances supervised by State Trustees, yet he had on-going problems in trying to arrange to use his finances to find suitable accommodation. You will see that at the end of [redacted] life he was in and out of rental accommodation, yet had he been able to establish his own accommodation it could have had a positive and settling effect on him. The relationship between State Trustees and mental health patients is a matter that I believe needs to be examined;

(d) I have referred above to the need to take account of the potential usefulness of 'case conferencing'. The crucial point for me concerning 'case conferencing' is that any conference relating to significant changes to a patient's treatment, care, accommodation and release into the community should only occur with the input of the patient's primary carer/family member, and access to all treatment notes.

(e) In talking of case conferencing, I am reminded of circumstances that caused me considerable grief in terms of my relationship with [redacted] When [redacted] and I had meetings with his case manager I would be asked to meet with her first. I considered those discussions to be confidential to give her some understanding of matters that she may not have been aware of. For instance, I might tell her that [redacted] has been acting up and has been aggressive and difficult. When [redacted] was invited into the discussion the case manager would start off by telling [redacted] that I had informed her that he had been aggressive and difficult. That would bring the roof down with [redacted] immediately accusing me of getting him into trouble and any trust I had with him was gone. It always took me a long time to rebuild trust with [redacted] and the end-result for me was to simply stop telling the case manager anything.

There must be a better way of establishing communication between case managers and the carer/family member. If my experience means anything it simply cannot work.

Question 6:
What are the needs of family members and carers and what can be done better to support them?

I have referred above to the effect of [redacted] s illness and treatment had on me. It led me to attempt suicide and the memory of that time remains with me to this day. In question 4 (a) above, I have suggested that some agency should be provided that can assist in providing information and guidance about mental health generally, and where necessary, more specifically about treatment. It may be appropriate to consider that the agency might also provide assistance for carers/family members who themselves need some form of care and support. That care may be a referral to an appropriate health practitioner, or to assist in arranging or supporting some form of respite to enable the carer/family members to get some form of a break from the incessant and grinding demands of their loved ones.

Question 10:
What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?
I have listed some ideas above and I will not repeat them here other than to say that one of the critical requirements in the mental health system is the training and development of mental health nurses. However, it is not only nurses that need that support, security staff are often used in mental health facilities and I strongly urge that they need to be fully trained to deal with mental health patients, and their employment should be conditional on attaining training and development that is specific to mental health patients.

The same approach should be taken with Police. They must be trained to deal with mental health patients. Police in armour with snarling police dogs is not the way to deal with complex mental health problems, nor is the aggression and macho behaviour of individual police helpful in any way in dealing with mental health incidents. And finally in relation to Police, attitudes of indifference and ignorance concerning requests for help or guidance from carers and/or family members create immense problems.

Question 11:
Is there anything else you would like to share with the Royal Commission?
As a concluding comment I would like to thank the Government for undertaking this Royal Commission. I entered into the mental health system approximately nineteen years ago when my son became ill. I was totally ignorant of 'mental health' and what that might mean to an individual. It was the most frightening experience of my life and culminated when my son lit fire to himself and died in February 2014. Those ten years: my son's illness, his treatment and his death have changed me in ways that are with me today. They are not good feelings and my regret is that I was unable to assist [redacted] in ways that could have changed his life.

I couldn't do anything for [redacted] but hopefully my experience and my comments to the Royal Commission will do something to improve a system that is in desperate need of major change.

[redacted]

THE DEATH OF [redacted]: LOOKING FOR ANSWERS

PREPARED BY [redacted]

2016

THIS DOCUMENT IS WRITTEN IN LOVING MEMORY OF MY SON

[redacted]

[1] I would like to thank [redacted] Lawyer, [redacted] Lawyer Pty Ltd for his assistance in the preparation of this document.

THE DEATH OF [redacted]: LOOKING FOR ANSWERS

This document has been written to set out my concerns relating to the mental health treatment of my son [redacted]

[redacted] died in 2014 when he poured petrol over himself and set himself alight. This was not the act of suicide but the act of a person who had serious mental health issues. It was an act that should never have occurred.

This document sets out my concerns about the reasons why [redacted] died the way he did. It is my view that he died because he was abandoned by the mental health system.

[redacted] had some difficulties at school as a young adolescent, and he was no angel, but he was a young man with dreams and aspirations. He wanted to become a tradesman. Unfortunately, all of his dreams vanished the day he was hit by a motor bike.

For the next ten years [redacted] experienced various mental health facilities and so many different doctors, nurses and others in the mental health system that it is impossible to recall them all.

During that period [redacted] had numerous diagnoses but none that were ever finalized. There were competing theories and assumptions about whether he should, or should not be treated in particular ways and a range of drugs were trialled on him.

Amongst all of this [redacted] began smoking marijuana and drug tests in the various facilities also identified that over time he was taking other illicit drugs. [redacted] behaviour became erratic and he was increasingly difficult to deal with. His drug taking was seen by various clinicians as the reason for his threatening and difficult behaviour, yet there were times when he was not drug affected that he was paranoid and delusional. No definitive diagnosis was ever made.

[redacted] was a potential time-bomb waiting to go off. This was acknowledged by a number of doctors yet he was evicted from the mental health system and sent back into the community to fend for himself.

Eventually, and in retrospect, inevitably, [redacted] took his life. Why did he do so? We will never know, but we can be sure that he gave the mental health system many warnings of what he was likely to do. [redacted] had a delusional sense that he was both invincible and regenerative. If confronted with fire, he said, he would regenerate. Unfortunately, the mental health system did not listen to him.

[redacted]

THE DEATH OF [redacted]
LOOKING FOR ANSWERS

Introduction:

This document is based on information obtained from various letters, reports and similar sources from mental health facilities, doctors, nurses and other mental health staff and clinicians which relate to the treatment [redacted] Unfortunately, I do not have access to a complete set of documents, and in that respect, there may be additional information that will add light to the issues I have raised.

Notwithstanding any gaps that may exist in the material that I have used it is my belief that I have been able to show that there were demonstrable gaps in the treatment of [redacted] and that his death was brought about by a system which failed to respond to a range of clear and observable warning signs that indicated that [redacted] was a high risk to himself and the community.

Background:

This section provides a brief understanding of the circumstances that occurred in the two years from the time [redacted] was hit by a motor bike.

The two year period was extremely difficult for me as I was dealing with a range of behaviours from [redacted] that made little sense. It seemed that he had been cleared medically yet I was aware that he was exhibiting the most peculiar symptoms including mood swings, talking to himself, crying for no apparent reason and exhibiting aggression and anger that I had never seen before.

I sought assistance throughout this period with little success and it was only with [redacted] referral to [redacted] Health that at last we seemed to have found someone who could assist us.

Unfortunately I was not to know that the process would take about ten years and would end with [redacted] death.

Comment:

Almost from the time [redacted] came home from hospital in 2004 he seemed to be delusional and it got worse overtime.

He either talked to the TV or claimed it was talking to him and he was concerned that I was trying to poison him in the food I was preparing for him.

[redacted]

The following extracts are taken from 'Confidential Neuropsychological Report, [redacted] to [redacted] /2006.

[redacted] was hit by a motor-bike on [redacted] /2004, when he was 14 years of age. He was taken to [redacted] Hospital and remained an inpatient for two weeks. He was diagnosed as having a traumatic brain injury, deep laceration to his left calf, a fractured nose and facial lacerations. He had bruising to his scalp in the left temporal region and the occipital region. A CT scan failed to detect any intracerebral pathology. He underwent plastic surgery for his left leg on 25/2/2004 and had surgery on his nose early in 2005.

[redacted] reported a number of post-accident problems. He stated that he had previously had poor vision in his right eye, but now his left eye had deteriorated. He also said he had intermittent ringing in his ears, a permanently blocked nose (but no anosmia) and frequent headaches.

He also stated he had never felt the same since the accident and he was finding life very difficult. He said he had previously been very easy going but had become moody and prone to outbursts of anger. He said he mainly kept to himself or saw one close friend. He said he had noticed problems with his memory and that sometimes he went blank or forgot where he had put his belongings.

His mother stated that [redacted] had been forgetful before the accident but that he had become worse. She said he suffered mood swings and often sat in his room yelling or crying.

[redacted] was of a young age when he sustained his brain injury and it is known that there can be a worsening of the cognitive effects overtime because the individual does not keep up with his age peers in terms of cognitive development.

Since it is two years since the injury was sustained, [redacted] neuropsychological status is unlikely to show any substantial improvement.

A compensation claim was made to the Transport Accident Commission (TAC), however, the TAC Consultant Neuropsychologist concluded that [redacted] cognitive and behavioural problems were due to pre-existing problems and secondary to his psychiatric condition. The acquired brain injury was considered to be very mild or mild given the severity indicators ... It was also argued that [redacted] psychiatric condition was not caused by the accident due to a reported two year delay in the onset of symptoms following the accident. He received an out-of-court settlement for other injuries sustained in the accident.

Extracted from Dr. H. [redacted] 'Discharge Summary', [redacted] /12

Psychiatric History: 2006 – 2011

The focus of this section is the period between 2006 and 2011. The content of the section is extracted from 'Discharge Summary', Dr. [redacted] Clinical Neuropsychologist, [redacted] 29/6/12.

The section is relatively brief and is designed to demonstrate the extent to which [redacted] was hospitalized and the deterioration in his mental health.

October 2006

history of paranoid ideation. Other symptoms at that time included irritability, agitation, [redacted] was referred to [redacted] health following an approximately 12 months impulsivity and lowered mood.

March 2007

[redacted] was admitted to [redacted] health inpatient unit for one day due to medical non-compliance. He was discharged on a Community Treatment Order (CTO) which he remained on until May 2007. He was reportedly stable during that period (on fortnightly depot medication), compliant, and moderately engaged.

October 2007

[redacted] was admitted to [redacted] Health inpatient unit for four days due to irritability, social withdrawal and paranoia in the context of medication non-compliance. He was discharged with fortnightly depot medication. His mental state reportedly fluctuated in the community and his medication was increased.

January 2008

[redacted] was admitted to [redacted] Health inpatient unit for ten days due to deterioration in mental state with increasing paranoia and aggression. He remained compliant with depot medication. There appeared to be a reduction in his paranoid ideation, however, he continued to demonstrate labile low frustration tolerance and outbursts of anger. He was discharged in May 2008.

August 2008

[redacted] was admitted to the [redacted] for four days.

February 2009

[redacted] was admitted to [redacted] for four days.

May 2009

[redacted] received support from [redacted] Mobile Support and Treatment Service (MSTS) under a CTO for three months with improvement in mental state. He was referred to the [redacted] residential rehabilitation program.

November 2009

[redacted] was admitted to [redacted] Health inpatient unit for six days following deterioration in his mental state in the context of medication non-compliance and the use of cannabis and alcohol.

March 2010

[redacted] was admitted to [redacted] for three weeks due to a relapse of psychotic symptoms (Paranoia and hallucinations) and had smashed a window at the Rocket program. A urinary drug analysis indicated that he had been using cannabis. [redacted] was discharged to live with his father but was not compliant with follow-up and could not be contacted by [redacted] Mental Health Service.

June 2010

[redacted] was admitted to [redacted] for three and a half weeks. He had been taken to Sunshine Hospital Emergency Department by police in the context of disorganised behaviour and deteriorated mental state. He was transferred to the [redacted] Mental health Rehabilitation Unit [redacted]). His mental state rapidly improved. He was discharged in November 2010 with follow-up support from the MSTS.

February 2011

[redacted] was admitted to [redacted] for nine days.

March 2011

[redacted] was admitted to [redacted] for eight days. He was discharged to the [redacted] Service Community Care Units (CCU).

April 2011

[redacted] was admitted to [redacted] for thirteen days. He returned to CCU.

August 2011

[redacted] was admitted to [redacted] due to escalation in aggressive behaviour. He allegedly assaulted a co-resident at the CCU and there were reports of three assaults against staff members during his stay. He also reportedly damaged property and made threats to kill staff. CCU staff suspected illicit drug use and [redacted] had not been engaging in the rehabilitation program at the CCU.

The SAAPU inpatient progress notes indicated that [redacted] was often irritable, argumentative and verbally aggressive towards staff but then settled over the course of his admission.

Psychiatric review did not reveal acute psychotic symptoms as [redacted] denied hallucinations, delusions or paranoia. However he did demonstrate some fixed delusional beliefs about having been raped in his sleep at CCU. He discharged himself against medical advice on 13/11/11.

November 2011

[redacted] was located and readmitted. Discharged to private rental with support from MSTS on 7/12/11.

Medical History

Other medical history includes substance abuse. Hepatitis C diagnosed in 2004 and scabies in March 2011. [redacted] substance use history is unclear, his medical file notes indicate

that alcohol and cannabis use has been confirmed and heroin and amphetamine use has been suspected.

Final Diagnosis
Acquired brain injury; Schizophrenia

In late 2011 I began to realize that I was not coping with the demands that were being made of me in relation to [redacted]. He was absconding on a regular basis and each time I called the Police for assistance they would refer me to the mental health facility. When I would call the mental health facility they would tell me to call the Police. I was desperate for assistance and some guidance as to what I might do in relation to [redacted] and his problems but there did not appear to be anyone or any organization that I could turn to.

I eventually decided that I had no other option than to take an overdose of Valium. I was found by [redacted] and a friend and they called an ambulance. I was sent to [redacted] Health where I recovered.

I was treated by a psychiatrist for a while but I realized that I needed to get back on my feet if I was going to be able to assist [redacted] so I stopped seeing the psychiatrist and just got on with things. Unfortunately, for [redacted] matters were to get much worse.

[redacted]

2012 – 2013

This section is the centre-piece of my analysis of the key issues that relate to my concerns about [redacted] treatment. [redacted] died in February 2014 yet throughout 2012 and 2013 there were numerous warning signs that he was escalating in terms of his behaviour and a number of concerns were expressed by clinicians that he was a potential danger to himself and the community. Unfortunately, these warning signs were either ignored or dismissed as he was eventually cast out of the mental health system to fend for himself.

On 10/6/12 [redacted] was admitted to the [redacted] Health [redacted] Adult Inpatient Unit. The following extracts are taken from a 'Discharge' document dated 29/6/12 [Dr. [redacted]

Reason for Admission/Presenting Problem
22 year old unemployed man, previously living in CCU [redacted] (Case Manager [redacted] currently being managed by MST, with a history of ADHD, ABI, and Schizophrenia. He also has a history of multiple admissions to [redacted]J, the last in November last year.

[redacted] was taken by police to [redacted] and admitted with a revoked CTO due to deterioration in his mental state.

... He had been using THC and last taken 2 days ago.

Treatment and Outcomes
... His rapid deterioration in mental state before admission and his rapid recovery suggest substance abuse, and a urine drug screen was positive for cannabinoids but nothing else of concern. He was reviewed by both the hospital treating team and the MST team, who felt he was able to be managed in the community. He was trialled on weekend leave before being discharged from the ward.

The following extracts are taken from a document dated 13/11/12 [Dr. [redacted]].

... Since his referral to the mobile support team in December 2011 he has been substance affected on numerous occasions (alcohol, THC, amphetamines) and these factors have contributed to his most recent admission in February 2012. [redacted] has negligible insight into his mental illness and the impact of his substance abuse on his physical and mental health as well as his relationships with his family.

He poses a significant risk not only to himself through misadventure but to members of the community and the various services involved in his care. [redacted] prognosis is complicated by his acquired brain injury and immature personality structure. [redacted] can present as overfamiliar and disinhibited especially toward female staff.

Comment:
The statement [redacted] poses a risk to himself and members of the community was like a flashing red light of warning to me. If that was the case, why was he literally cast out from the mental health system to fend for himself? Within 15 months of this warning [redacted] died. There were more warnings but none that had any influence on his safekeeping.

[redacted]

Since the first edition of this referral [redacted] has had two subsequent admissions to inpatient units [redacted] June 2012 and [redacted] July 2012) each involving the police. On both occasions [redacted] has been threatening towards either MSTS clinicians or the general public. He is currently absent without leave from [redacted] – approximately 10 days.

A concern has been [redacted] increasing vulnerability to exploitation by people due to his social isolation. At present, [redacted] own family (mother who has been primary carer) no longer feel safe to visit him at home and likewise MSTS clinicians have expressed concerns regarding OHS issues due to the unpredictability of who and in what state people may be in [redacted] home. On one of his most recent admissions a blood filled syringe was found on [redacted] coffee table and at last admission [redacted] was making threats to kill while carrying a steel pipe.

Referral agencies expected/desired outcome/discharge expectations:
In retrospect, it would appear [redacted]'s previous discharge from [redacted] (2011) was premature. [redacted] requires a more prolonged admission to [redacted] both for the purposes of containment of the risks he poses to himself and others in the community, and given his limited capacity for insight orientated approaches to recovery, an attempt at more of a behavioural modification approach to some of the more problematic and anti-social aspects of his behaviour would alleviate some of the stress for primary carers. None of the rehab options so far trialled by MSTS – [redacted] – CCU/Care Coordination packages have had any significant impact. [redacted] has had no real commitment to any of these options.

Reason for an enhanced treatment plan:

1. **To reduce risk to [redacted] and others**
[redacted] dynamic risk factors are high. He has a significant history of homelessness, episodic psychosis (in the context of drug use), escalating substance abuse, poor and at times openly hostile engagement with mental health services, conflictual relationships with family. All of these factors increase risk to others, including clinicians, family members and the general public. In the past [redacted] has had recurring acute admissions in the context of substance use and deterioration in mental state, threats and violence and aggressive behaviour. These factors are superimposed on the static risks of past assaultive behaviour, probable acquired brain injury, significant anti-social personality traits, childhood ADHD/conduct disorder, early maladjustment and poor social supports.

2. **To assist services (mental health and other) in responding to [redacted] needs**
This Plan will aim to guide safe, immediate and effective treatment for [redacted] and management during periods of relapse and hospitalization. [redacted] behaviour can be dangerous to himself, clinicians and others in the community. He can be verbally and physically aggressive. [redacted] has an extensive history of non-engagement with MH services, poor compliance, and itineracy. [redacted] is resentful of and antagonistic towards MH services.

Treatment and management history
[redacted] has been involved with mental health services since 2007. During this period of time he has had multiple exacerbations of his psychotic illness in the context of non-compliance with medications and significant drug abuse. [redacted] longitudinal management is further complicated by his personality traits and premorbid ADHD.

Since 2007 [redacted] has had multiple acute inpatient admissions, CCU, [redacted] and multiple attempts to manage him in the community. All of these attempts to manage him have hindered by his lack of engagement and extreme negative attitudes to treatment.

[redacted] has been trialled on multiple oral medications for psychosis and ADHD which were unsuccessful due to non-compliance. Currently, he is on a stable dose of depot antipsychotic medication. He is reasonably stable in his mental state despite on-going substance use.

When unwell or substance affected, [redacted] presents as loud and argumentative, easily irritated and prone to aggression. [redacted] presents with paranoid and persecutory delusions (sperm has been tampered with, cameras are monitoring him, he believes he has been raped by a dog). He is more disorganized in his behaviour with formal thought disorder.

[redacted] does not usually present with clear early warning signs. When not using substances [redacted] can be reasonable and engage in conversation. Relapse is sudden and in response to substance use.

Accommodation

[redacted] have referred [redacted] to SRS's in the [redacted] but they have refused to offer accommodation after reading the referral. The refusal to house him is based on his pat aggression and violence and ongoing drug use.

[redacted] has been blacklisted from private rental due to extensive property damage.

Comment:
Given the deterioration in [redacted] mental health and his aggression and violent behaviour, coupled with his blacklisting of both mental health and private rental, surely it would have been evident to the clinicians concerned that if he was to be 'released' into the community it was likely to be either sub-standard accommodation or homelessness, or a combination of both, with all of the dangers they present.

[redacted]

The following extracts are taken from a letter to [redacted] Intake Worker [redacted] from Dr. [redacted] Psychiatry Registrar, dated 29/3/2013.

Risk History

Mr. [redacted] has threatened self-harm in the past and there is documented query of an attempted hanging during outpatient treatment at [redacted]

There is a pattern of unpredictable and impulsive behaviours often but not always related to psychotic symptoms, including verbal outbursts, intimidating behaviours, physical altercations as victim and perpetrator, property damage, illicit drug use, threats to harm and kill others.

During this admission to [redacted] Mr. [redacted] has verbally threatened staff of all professions and has made threats of vendetta and revenge on individual doctors in the future. He has a high profile on the ward amongst other inpatients and has been intrusive, verbally

antagonistic, physically intimidating and threatening with various co-residents, and sexually inappropriate with females, including over-familiarity with nursing staff. He has recently cornered and locked a female cleaner in his room and made sexual threats to her, requiring a code grey. Last weekend he was assaulted by a male co-resident after a day of verbal conflict.

Mr. [redacted] has a history of absconding from mental health units, including smashing hospital windows to abscond from [redacted]J, and whilst on escorted leave with his mother. He cannot be located by hospital staff or family and has been reported as a missing person on several occasions.

Mr. [redacted] has been observed during episodes of behavioural disturbance and thought to have been intoxicated with substances however he has not cooperated consistently with urine drug screens. During [redacted] admission he has returned urine drug screens positive for cannabis and opiates and negative screens on other occasions.

This has not been related to his leave privileges or periods of restriction and syringes and needles have been found hidden in his room.

Comment:
It is a concern to me that although [redacted] returned positive urine drug screens on occasions, there were other occasions where it seems that his 'behavioural disturbance and thought' occurred with no positive drug screens. My concern is that there appears to have been an assumption that [redacted] behaviour and conduct was always 'drug related'. Whilst I accept that drug use was a factor in some [redacted] behaviour I do not believe that to be always the case. My view seems to be confirmed by the apparent 'uncertainty' by various clinicians as to the exact diagnosis that could be applied to [redacted]

[redacted]

Treatment at [redacted]

Mr. [redacted] was without treatment for several months when he was readmitted to [redacted] for two weeks prior to transfer to [redacted]J. He was assessed as having symptoms of inattention and impulsivity satisfying the criteria of adult ADHD and was commenced on atomoxetine, with reasonable effect both subjectively and objectively.

He was observed for a significant period of time without antipsychotic treatment however due to fluctuations related to his guarded mental state and periods of substance abuse, poor medication compliance and absconding, this was not a definitive exercise that informed the process of diagnostic clarification of his psychotic illness. His psychotic

symptoms of paranoid persecutory delusions (nursing staff tampering with his food, medication and body; replacing his mother with another person) and ideas of reference from Television and radio were observed by nursing staff during distress and emotional liability and would be expressed in the presence of doctors only rarely during episodes of intense anger such as when the mental health review Board upheld his involuntary treatment order. Rapport has been difficult to establish with Mr. [redacted] due to his consistent denial of his behaviour despite witnesses, inability to take responsibility for his actions, his antisocial interactions with staff and apparent lack of remorse. Mr. [redacted] has not displayed any insight into his presentation.

Comment:
I am not qualified as a medical doctor or in the field of psychiatry. I am however [redacted] mother and I lived and breathed every step of the way with him. I was well aware that he was spiralling out of control and the material I have quoted supports that fact. Why then, wasn't some action taken to do something to contain [redacted] and restrict his movements? Why was he literally allowed to come and go? I am sure that if some action had been taken to address [redacted] consistent decline we would not be discussing his death.

[redacted]

A second opinion for diagnostic clarification and management advice was sought from Dr. [redacted] who in early March 2013 acknowledged the "uncertainty of effects of acquired brain injury with possible organic psychosis, or to the presence of on-going Schizophrenia or soley to the effects of illicit substances" and recommended "an extended stay at [redacted] ... agreeing with a trial of antipsychotic medications in the absence of illicit substances in order to confirm if Mr. [redacted] does indeed suffer from Schizophrenia ... to determine the functional impact of the brain injury".

His risks to self and others were acknowledged and highlighted was his high risk of relapse due to non-compliance and substance abuse with probable outcome of being remanded in custody.

Comment:
The earlier expression of concern for [redacted] risk was November 2012. This expression of concern is March 2013. There did not seem any doubt that he was a risk to himself and others. I find it ironic that it was suggested that his high risk of relapse might result in being remanded in custody when in fact the real risk was more profound.

[redacted]

Current diagnosis and formulation

... The exact nature and significance of the head injury on the development of his psychiatric illness remains unclear (organic psychosis versus an indirect mechanism) however he clearly did not have the opportunity to regain any lost function and may have in fact progressed in those neurocognitive deficits which is now re-emerged as manifest ADHD. Undeniably, using the stress diathesis approach, the accident and injuries have contributed to the emergence of psychosis through psychological stresses of loss, frustration, physical inadequacy and anger.

Comment:

When I read the following words: 'The exact nature and significance of the head injury on the development of his psychiatric illness remains unclear ...', I cannot help but say that I intuitively knew that from the time of the head injury [redacted] *was a changed person. It may have taken two years to have developed to the point at which he required psychiatric care, but during that two-year period I observed the slow disintegration of my son. I do not believe the clinicians have understood the extent and nature of the head injury and they consistently made wrong assumptions about his behaviour.*

[redacted]

From collateral it is accepted that Mr. [redacted] substance abuse began after the head injury and first episode of psychosis and thus can be seen as a perpetuating factor.

Mr. [redacted] displays no insight into his presentation, impact on others and does not accept responsibility for his actions nor show remorse. His risks to self through misadventure, and risks to others have been increasing, relative to progression of illness, substance abuse, non-concordance with treatment and reduced ability of family to support him. Mr. [redacted] has reasonable goals for the future however does not acknowledge any mental illness nor identify that treatment and abstaining from drugs are necessary for his rehabilitation.
The following extracts are taken from material prepared by Dr. [redacted] Consultant Psychiatrist, [redacted] Mental Health to professor [redacted] Mental Health, dated 9/7/2013.

Risk Assessment:

The HCR-20 is a set of professional guidelines examining the presence of risk factors that have been found to empirically predict violent behaviour and assist to give an indication of the category of risk in which an individual falls. The HCR-20 contains 10 historical (past) variables, 5 clinical (present) variables and 5 risk-management (future) items that are designed to capture relevant past, present and future considerations in determining risk of violence.

The historical scale is static and based upon historical variables that are not subject to change. Mr. [redacted] demonstrates evidence of several historical risk factors including *previous violence, young age at first violence incident, relationship problems, substance abuse problems, major mental illness and prior supervision failure.* An assessment of personality was omitted.

The remaining two scales of the HCR-20 are comprised of dynamic (i.e. changeable) risk factors. With respect to the clinical scale Mr [redacted] displays *lack of insight, active symptoms of major mental illness, impulsivity and unresponsiveness to treatment.* Negative attitudes which relate to general attitudes to society rather than specifically to treatment were not assessed today. On the risk management scale, Mr. [redacted] shows definite evidence for *plans lack feasibility (no plans other than to get licence), exposure to destabilisers (substance abuse), non-compliance with remediation attempts and stress (poor capacity to manage minor stressors).*

On the basis of the above risk factors, Mr. [redacted] would be in a group of persons with a *moderate to high* risk of violence towards others. A likely scenario would be violence in response to psychotic symptoms or towards individuals who frustrate his wishes. Interventions which specifically target those dynamic risk factors above, in particular the psychotic symptoms and substance use, have the greatest chance in decreasing Mr. [redacted] level of risk.

Comment:
These comments are more precise than the earlier statements of risk presented by [redacted] *in that they quantify the risk as 'moderate to high'. The difference is that these comments suggest the risk is more likely to be towards others. We know, of course, that the risk was, in fact, related to himself.*

It is interesting to contrast the comments in this section, and indeed other references to risk from clinicians, with the following extracts from 'Total Care Progress Notes' dated 24/7/2013 and signed off by [redacted] *Nurse Division 1:*

'... Writer thanked [redacted] *for returning* [redacted] *to the unit last night after he had gone AWOL on the weekend. It was explained to* [redacted] *that* [redacted] *staff had gone to great lengths to* [redacted] *from absconding but he was determined to do so. She was very understanding of this and stated that he would continue to abscond and could not be contained. Writer explained that seclusion could contain* [redacted] *but it was an extreme course of action which is not warranted given that* [redacted] *has not constituted a serious risk to himself or others when in the community.* [redacted] *agreed with this and stated that she would not want* [redacted] *secluded just to stop him from absconding...'*

Opinion and Recommendations

1. ...

2. On the basis of the information available, I consider a diagnosis of Schizophrenia the most likely. Certainly, it is likely that an exacerbation of symptoms, particularly agitation and irritability, occurs when he has used substances. Clinical documentation contains many references to disinhibited behaviour occurring when delusions are not evident. This behaviour includes sexually inappropriate comments to female staff and patients, recurring despite staff intervention, intrusiveness with co-patients and odd behaviour such as removing his trousers and passing wind in the public areas of the ward. These behaviours cannot be seen as being of advantage to him in his aim to be discharged from hospital. They may be the result of the head injury with executive dysfunction, although his previous head injury would not seem to be of sufficient severity to cause this. It is more likely in my opinion to be caused by his psychotic illness.

3. ... It is very difficult to assess whether any clinical changes are the result of substance use, substance abstinence or a response to an intervention. It also makes the assessment of his underlying personality very difficult. Assessing his behaviour, in particular his odd or seemingly inexplicable behaviour, is likely to be the most important means of determining his mental state, at least in the short term.

4. He requires an extended period of inpatient care and containment at [redacted]

5. ...

6. It would be worthwhile attempting to repeat the neuropsychological assessment. I wonder whether some of the deficits were due to the incipient psychosis at the time rather than a head injury ...

Comment:
Although Dr. [redacted] states that she considers ' a diagnosis of schizophrenia the most likely', she goes on to state that his behaviours 'may be the result of a head injury with executive dysfunction, although his previous head injury would not seem to be of sufficient severity to cause this'.

Different clinicians seem to refer to [redacted] 'head injury' as a potential source for his erratic behaviour yet dismiss it on the basis that it was of insufficient severity to be the cause.

I repeat the comments of Dr. [redacted] above who stated that:

'The exact nature and significance of the head injury on the development of his psychiatric illness remains unclear ...'

[redacted]

In July 2013, Dr. [redacted] Director [redacted] Psychiatrist, Department of Health, sent an email to Dr. [redacted] which included the following comments:

I have read the report provided by Dr. [redacted] (report dated 4th March 2013) and the report of Dr. [redacted] (report dated 25 June 2013). I believe both reports are carefully considered by the authors and provide sound advice; it is most unlikely that I would make any suggestions which are in disagreement with the recommendations provided in the reports. Specifically, it is most unlikely that I would support the discharge of the patient from [redacted] given his risk profile and the presence of ongoing psychotic symptoms.

On 18 September 2013 Dr. [redacted] an email to [redacted] which read as follows:

Thank you for sending this on. I have reviewed the comments I made following a brief interview in February. I note that [redacted] staff have tried valiantly to engage with Mr. [redacted] and to establish a tolerable treatment regime for almost 12 months. I also note that such attempts have been largely unsuccessful. I think this relates to his probable acquired brain injury and previous ADHD with consequent impulsivity, poor judgement and problems in learning. I assume his mother is still administering his funds and that they are held by the State Trustees.

As discussed, in the context where we do not have access to a more secure but less restrictive environment (such as [redacted] or a medium secure unit), I agree that there is little benefit to Mr. [redacted] by continuing the admission to [redacted]...

On 25 September 2013 I received a letter signed by [redacted] Program manager [redacted] and [redacted] Consultant Psychiatrist, [redacted] which stated in part that:

As I discussed with you on the phone on 20th September 2013 the [redacted] Mental Health Rehabilitation Unit [redacted] treating team, after an extensive clinical review, including second opinion consultation ... have made the decision to discharge [redacted] from [redacted].

...

The treating team has been able to establish that [redacted] psychosis is largely the result of his illicit drug use and that depot medication, Paliperidone, is adequate treatment except when [redacted] escalates his drug use, particularly amphetamines.

[redacted] has spent long periods of AWOL in the community over the past 11 months and each time returned to [redacted] with no or minimal change in his mental state. He also finds accommodation, manages his finance and looks after himself adequately during these times without running into serious trouble with the Police.

Comment:
How did this decision sit with the numerous expressions of concern that [redacted] was a risk to both himself and the community?

Was the 'problem of [redacted]' simply dismissed because there was no appropriate facility for him, or was it that the treating team at [redacted] simply gave up because he was too hard to handle?

On what basis was it claimed that [redacted] was capable of finding accommodation, managing his finances and looking after himself adequately? None of these claims have merit.

[redacted] was literally incapable of the most basic issues including personal hygiene and eating appropriately.

[redacted] was 'evicted' on 30 September 2013. It was his death sentence as he was dead 18 weeks later on 13 February 2014.

[redacted]

If there is any doubt about [redacted] ability to find accommodation and look after himself adequately in the community, the following comments should dispel that doubt.

The following extracts are taken from a statement made by [redacted] Case Manager, to the Coroner following [redacted] death:

On 22nd November 2013 I met with [redacted] at his mother's house ... This initial visit was to assess [redacted] needs and look at all options. On this day he was quite unwell, he was delusional and paranoid, he was very guarded in his answers. He was talking about other people's blood running through his veins and other people watching him.

... he was more unsettled that any previous times I had seen him ...

Second meeting with [redacted] was on 11th December 2013 ... he was much more settled ... there was some delusional thoughts and conversations but definitely not so much ...

...

The next contact I had with [redacted] wasn't until 3rd February 2013 and that was a call from his mother who stated that there was an intervention order put in place from his sister and he was no longer allowed at the address and his mother requested for me to find accommodation on an urgent basis.

... I found him a booking of one week at the [redacted] Tourist Park ...

That only lasted one day due to his behaviour and I only found this out as his mother contacted me and stated he had been evicted due to behaviour.

The next point of call was [redacted] on [redacted] which I managed to get him a room there ...

...

On 6th February I had a phone (call) stating there had been several complaints about [redacted] knocking on doors asking people for smokes ...

On 7th February ... I got a phone call from [redacted] stating that due to his behaviours [redacted] had to leave ... I managed to find him a room at the [redacted] Motor Inn, [redacted] Road ...

[redacted] was quite settled and was reasonably happy due to the accommodation being closer to his mother's house.

...

On 13th February I had a message ... (which) stated that [redacted] was involved in a fire during the night and was taken to the [redacted] Hospital in a critical condition.

Comment:
The sequence of events as outlined by [redacted] were almost inevitable following [redacted] being 'evicted' from [redacted] All of the records and the experience of clinicians and hospital staff would have known [redacted] could not adequately look after himself. He was a time-bomb waiting to go off and unfortunately the circumstances on February [redacted]2013 were such that he lit the fuse, and the shame of it is that it did not have to happen. Had he been in secure accommodation under the care of the mental health system he would still be with us today.

[redacted]

Coroner's Inquest
The Coroner's Inquest included Witness Statements from various members of the Police, ambulance officers and individuals who were living at the Motel where [redacted] set fire to himself. The only people from the mental health system were [redacted] case manager and a person from [redacted] Hospital who had some familiarity with [redacted] mental health history.

I am prevented from using any material from the Coroner to explain my concerns, however, I can say that it seems that the position put to the Coroner as a starting point was that a combination of mental health issues, drug use and [redacted] belief that he could regenerate, led him to set fire to himself.

My concern at the Coroner's Court process is that there was little consideration given to the recent history that led to [redacted] being in the Motel in the first place.

I fully understand the Coroner's need to examine all aspects of the immediate circumstances relating to [redacted] actions and his subsequent death, however, the full story cannot be understood without considering why [redacted] was in the Motel given that he was suffering from extremely complex mental health issues.

I have set out in considerable detail the various assessments of a number of clinicians and it is clear that there was no consensus concerning the extent to which the initial brain damage might have been significant in the very obvious deterioration in [redacted] condition. In fact, from my perspective there was no consensus as to [redacted] diagnosis generally. What was evident was that he was a potential danger to himself and the community, yet even that was reversed when it was decided that he should be cast out into the community to fend for himself.

I wanted an autopsy done on [redacted] with a particular need to see if there could have been any clarity concerning his initial brain damage. Unfortunately, my request was rejected. As I have set out in this document, there remains considerable uncertainty concerning the extent to which the initial brain damage was significant in [redacted] condition.

Unfortunately, the Coroner was more concerned with the immediate circumstances that led to [redacted] death. Whilst they are important, it is my view that they will not provide the answers to why [redacted] set fire to himself. I believe those answers can be found in examining the way in which [redacted] was dealt with in the mental health system.

Discussion and Conclusions:
In writing this document I have tried to demonstrate that [redacted] death was unnecessary.

[redacted] presented as a complex and extremely difficult patient for clinicians and hospital staff. From my perspective, that alone should have been enough for the relevant senior psychiatric staff to acknowledge that he should not have been allowed to roam free in the community.

[redacted] was a high risk to himself and the community. That was acknowledged by a number of senior psychiatrists yet some of those same people declared that he was capable of independent living in the community.

All of the evidence indicates that [redacted] was not capable of independent living and that he continued to be a risk to himself and the community – why then was he cast out?

I acknowledge that in the letter confirming that [redacted] was to be 'evicted' from [redacted] a number of strategies were put in place to provide mental health care. Regardless of those strategies it was known to everyone that [redacted] was unlikely to make effective use of them and would almost inevitably not keep appointments. Given the knowledge that clinicians and hospital staff had [redacted] denial that he needed mental health care why did they put him in that position when it was obvious it would fail?

I am concerned that there were major deficiencies in the way [redacted] was treated and ultimately evicted from AMHRU. I am also concerned that the issues I have attempted to raise were not adequately addressed by the Coroner.

I am seeking answers to my questions for [redacted] sake and mine, so that I can move on in the knowledge that other complex and difficult mental health patients will not be treated as [redacted] was.

[redacted]